# CREATING A SMOKE-FREE ENVIRONMENT IN A MEDICAL CENTER: AN OVERVIEW

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IN February 1986 the Medical Board of Beth Israel Medical Center launched a committee study of policy on smoking for all its indoor areas. This study recommended a totally smoke-free environment in the Center. This was accompanied by advice for ample communication and clarification to the entire Beth Israel staff plus education and an offer of therapeutic support for those in need. The report was adopted on October 20, 1986 by the Medical Board and the Administration, and later endorsed by the Trustees.

Thereupon an implementation committee went to work. It divided its planning into two stages: toward announcement and toward effective date of implementation. The first stage ended at the Medical Center on March 17, 1987 with public and press announcements. After continued clarification, preparation and orientation of the staff, employees, and anticipated patients, the program went into effect on May 7, 1987, with further press coverage and public announcements. Thereafter, the implementation committee has continued to monitor the effectiveness of the program now in effect.

This review reports the steps taken in the evolution and promulgation of this policy, and shares both the process and substance of the experience at this institution with others who might have similar goals.

## PROFILE OF BETH ISRAEL MEDICAL CENTER

Founded in 1889, Beth Israel Medical Center is a major tertiary care hospital in New York City, located between First Avenue and Stuyvesant Park East and East 15th and 18th Streets in Manhattan. It has a total bed

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capacity of 934 beds and 56 bassinets. The central complex comprises 17 buildings, ranging in height to a maximum of 22 stories.

The Medical Center has 15 clinical departments. It is a major affiliate of the Mount Sinai School of Medicine, in which its attending staff hold faculty appointments. The Medical Center has an affiliation with the Rockefeller University which provides opportunities for joint research activity. The Phillips Beth Israel School of Nursing is an integral part of the Medical Center.

Its entire staff numbers 7,000 people. The Medical and Dental Staff totals 942, of which 729 are voluntary and 213 are salaried. Residents in training programs number 276, fellows 29. An additional 18 residency positions are in programs integrated with the Mount Sinai School of Medicine. Other staff includes 5,735 employees, of whom 1,068 are nurses, and 167 student nurses.

## PHASE 1. POLICY STUDY AND DETERMINATION (FEBRUARY–SEPTEMBER 1986)

The writer owes to the University of California Medical Center at Los Angeles the impetus for proceeding with this concept, from a news item of December 25, 1985,[1] announcing their intention to "ban smoking next year in all indoor parts of its hospital and clinics" as of January 1, 1986. This ultimately led to a decision by the Medical Board of Beth Israel Medical Center in February 1986 to study such a policy for our institution ("to consider the advisability of instituting a ban on smoking within the indoor parts of the Medical Center"). A policy study committee of 10 with the writer as chairman was appointed in consultation with the president of the Medical Center. Ample authority and broad representation were granted to assure all points of view from smokers and nonsmokers and input from staff physicians as well as from key administrative departments.

The committee met monthly. At its organizing session members were urged to depersonalize their approach, to deliberate as trustees to formulate the best possible policy goal with guidelines for gradual future fulfillment ("perhaps the year 2000"). Subcommittees studied the following areas: existing center policy on smoking and its precise application; status in the nursing stations and adjacent areas; experience at representative hospitals in metropolitan New York and elsewhere; careful on-site inspection of the entire institution and interviews with patients, visitors, and staff members.

Views of smokers were assured by ample representation in the committee as well as by intimate discussion with smokers among all levels of the hospital staff structure. The latter was done on an individual basis as well as with the many committee visitations throughout the institution. The same

care to ascertain all viewpoints was taken with patients and with visitors during these months of interviewing and deliberation.

It was coincidental (and welcome) that 1986 marked the significant pronouncement by the U.S. Surgeon General on the hazards of passive smoking,[2] added to the long recognized, uncontestable hazards to those who actively smoke. On all sides (governmental at all levels, respected national medical organizations, medical experts) it was becoming the so-called "year of the non-smoker."[3-19]

After six months of data gathering and discussions, the Committee on September 24, 1986 decided on a policy recommendation, namely:

> ...that smoking should be banned from the Center's indoor campus area; that this should apply to all personnel who serve, are served or who otherwise visit Beth Israel Medical Center....
>
> ...public announcement of such policy should be combined with planning for its implementation....will require careful planning and ample communication and clarification to all segments of the Beth Israel staff, professional, administrative, and non-professional....communication, cooperation and publicity at all levels are deemed crucial to eventual success in effecting this major policy change....prepare for an accompanying far-reaching educational campaign both for the awareness and cooperation of the non-smokers in our hospital campus environs and for those current smokers to be encouraged and assisted toward a non-smoking state.

This report and its recommendations were promptly adopted by the Medical Board and the Administration, with subsequent endorsement by the Trustees.

## PHASE 2. IMPLEMENTATION

### STAGE 1. PREPARATION FOR ANNOUNCEMENT (OCTOBER 1986–MARCH 1987)

Upon adoption of the policy recommendations, the president of the Medical Center constituted an implementation committee with the writer as chairman. This new committee retained the vice-presidents in charge of operations, human resources, and nursing from the policy committee but added a majority of new members from key services: public affairs, security, health education, chemical dependency, patient representative, patient admissions, engineering, as well as the past and current presidents of the medical board. An administrative assistant was assigned for the committee chairman. That the committee still included a sizable number of smokers insured that viewpoints and problems of smokers in accommodating to the forthcoming policy were kept in mind.

After its organization, subcommittees were appointed to deal with public affairs, education and orientation, and special concerns related to the Medical

Center's chemical dependency and psychiatric services. The committee recognized the need for adequate time to prepare carefully for announcement. It was evidenced by postponing such dates from, at first, November 20, 1986 (Great American Smoke-Out Day) to January 1, 1987, and then to January 30, 1987. Finally, due to need for further time to complete technical arrangements, it was further delayed so that public announcement was not made until March 17, 1987 (A-Day).

During these four months intensive preparations were being made by the center's department of public affairs, with whom the committee worked closely. These experts undertook arrangements for press and television coverage and precise timing for posting informative signs throughout the center; for written advance notice in the center newspaper, as well as ordering of buttons, desk tent signs, and key posters. The last three items actually were triple-usage of a specially commissioned artist's painting of an appropriate scene bearing the selected campaign theme: "Let's Clear The Air." This same attractive painting was incorporated in the buttons, tent signs, and the enlarged posters which began to appear throughout the center.

Most effective was a seven-minute taping of about 40 people interviewed briefly at the center in these late January and early February weeks. They were unrehearsed, selected strictly at random from all representations of the hospital people—administrators, professional and nonprofessional employees, visitors, patients. Smokers and nonsmokers were included, as was readily apparent. The chairman had urged that the tape be low-key, unrehearsed, and genuinely credible. That goal was accomplished. This taping was first aired publicly on the day of announcement at all entrances to the center and throughout that week, and was strategically placed at the paycheck areas on payday.

During these preparatory weeks and months, health promotion and nonsmoking support programs were being conducted by the director of health education and her staff in close coordination with the department of human resources. Courses were conducted for interested employees during the noon hour, cost for which was mostly defrayed by the institution. It was continuously made clear to these employees that the smoking cessation policy applied to their presence in the center and not necessarily to their total life habits, unless they wished to do that.

A special subcommittee, chairman of which was chief of the department of medicine's division of chemical dependency, was still assiduously tracking the special needs of drug-abuse patients. In this stage, contrary to the earlier decision finally taken during policy formulation, some had qualms about their special needs. From the reports of this subcommittee it became apparent that

special (albeit temporary) "stretch-out" exceptions would be needed for these patient floors.

Throughout these months, commencing late in December 1986, the chairman undertook in person carefully to orient all the "captains" in the center to what was coming, and thereby to enlist their early understanding and support. This comprised more than 50 people, including 24 administrative (nonprofessional) departmental directors, 15 clinical directors, and a dozen senior administrators. Some smoked. Most were kind enough to sit down with the chairman, sometimes in twos and even threes, to hear what was forthcoming, and why. The "why" was essential, particularly the following two points: the hazards of passive smoking, now an acceptable claim, was the take-off basis; and a special added responsibility therefore falls upon the center as a health care "employer," as distinct from an ordinary industrial, corporate or other type of business employer.

These two points were stressed as making it indefensible for the center not to move on this issue. The immediate goal was to enlist them as "captains" of their department teams, which, with rare exception, they accepted enthusiastically and effectively. The aim was for the mass of the employees in the institution to hear about the coming program from all sources, including their respected top leadership as well as immediate supervisors.

In addition, before public announcement, the president of the center and the chairman met on January 22, 1987 with *all* senior staff, comprising many of the same 50+ senior people already reached, plus all next level supervisors, and discussed the planned program. Soon thereafter a carefully prepared explanatory memorandum was issued to all center personnel over the signatures of the chairman of the board of trustees, president of the center, president of the medical board, and chairman of the implementation committee.

The writer spent time during February with the 170 student nurses in four group sessions to explain the coming program and to invite both their understanding and cooperation. He also stressed the program for support for those among them who were smokers and would seek personal assistance in compliance. Here again the point about its application to the hospital interior was made clear, although they were also urged to consider it for themselves on a broader basis. Similarly, he spent two sessions with the senior nursing staff, who were generally supportive and accepting, but he sensed a "let us see" minority reservation.

The implementation committee met regularly every two weeks and kept abreast with the work of the subcommittees. The chairman stayed in touch with all of these principals, particularly the subcommittee chairmen, and was

in frequent communication with the president of the center and the president of the medical board.

All this preparatory activity—with the usual word-of-mouth spread of news in a hospital environment—publicized the intended policy well. The videotapes greeted the entire staff early on the morning of March 17, 1987 at the five main hospital entrances by which they came to work or left work. It was a gala day. Press and radio coverage and television interviews also spread the word to the public and kept the committee busy in an exciting and possibly unfamiliar milieu.

## STAGE 2. PREPARATION FOR EFFECTIVE APPLICATION (MARCH–MAY 1987)

A major effort in these months made patients aware of the forthcoming new hospital policy, preferably before their admission. This called for coordination with those on the receiving end of the admitting process: admitting office, patient representative, patient relations managers, as well as attending and house staffs, who originate the process. A subcommittee identified and met these needs. A brochure was devised to inform the patient in advance. The attendings (and their office personnel) and residents were sent an explanation of how the process would work as of May 7, 1987.

An important feature of this period was belated but understandable uncertainty in many quarters, some at high levels of responsibility. Many qualms were readily allayed with reconsideration and reassurance. Some uneasiness went beyond that. In certain instances (e.g., the recurring disquietude about chemically dependent and psychiatric problem patients) it was decided temporarily to extend special smoking privilege—under closely monitored rules—to the several floors on which these patients were. For these the committee planned special allowance during the opening months. These privileges would be confined to designated lounge areas at specific, limited hours, on the approval of their physicians.

Some staff physicians later felt uneasy about "depriving dying oncologic patients" of the allaying balm of tobacco to a long-habituated smoker. This led to discussion at the medical board meeting on March 9, 1987, which broadened the limited, temporary privilege; similarly to allow these particular patients on the general medical-surgical floors the same type carefully drawn privilege at a limited hour each day (after lunch and after supper) in designated lounge areas, also upon the request and approval of their physicians.

Such were examples of the "hectic" activities that had added to the anticipated problems of preparing for "E-Day." On May 7, 1987, finally, it went

off well and as expected. The tapings were again exhibited at all entrances. Carefully prepared, informative, attractive signs were on time and in place, with dignified and persuasive phrasing of the new policy. The traditional, small "No Smoking" signs were abundant where need for reinforcement was still anticipated. Public relations staff had again done their work well. Press, television, and radio coverage were good. Interviews were granted by principals of the institution. Despite minor "bumps" here and there, it went off well.

These two months between announcing and effecting the program had an obvious momentum that worked favorably. This was a consequence of the careful preparations in the preceding four months.

### PHASE 3. POSTIMPLEMENTATION MONITORING (MAY 7, 1987–SEPTEMBER 1988)

The program has gone well, in fact better than anticipated. Starting with the first few weeks, when compliance was good but expected problems did arise, the program took hold—gradually, increasingly, visibly. The policy of planning generally for no "enforcement" as such beyond persuasion, following extensive preparations, has been fully justified by what has taken place.

Week by week, individual problems have decreased. When they occur, one or another of the committee or others have dealt with them evenhandedly, usually with good effect. Example: a plea for advice may come by telephone from a technician (nonsmoker) in the laboratory about occasional ongoing smoking in its lounge: "Is it permitted?" "No." "What can be done?" "Discuss the matter first with your supervisor." The writer might separately talk with the director of the department and perhaps later that week look at the area in question: generally the problem has been resolved.

Simultaneously, all levels of the staff were developing and manifesting a widespread pride at what they saw taking place. This growing pride was expressed repeatedly. Inevitably it was a step toward further and increasing compliance. In a sense the staff was pinching itself and shaking its head in pleased disbelief at the way the program was working.

Visitors (anew or returnees after an interval) also were impressed and remarking about the clean air ("Let's Clear the Air!") and the striking sense of general cleanliness. Added was widespread repainting and picture-placing which enhanced the appearance of the institution in the recent months.

Occasional pockets of noncooperation needed attention. As they arose they were met on an ad hoc basis with no fuss or embarrassment to anybody, generally by one member or another of the committee. When the subcommit-

tee resumed periodic inspections, their results were increasingly impressive. These revealed little to no transgression on the floors or in patient areas. An occasional employee lounge needed improvement. On occasion, they saw similar misuse of nonsmoking lounge by visitors and a rare patient. Steps taken to correct these were predicated on the value of prompt communication with the employees, the patients or the visitors on a mutually respectful basis. In these conversations each listened to the other. For our part we made clear the intent and basis of the institution's policy commitment. Nonetheless we listened carefully to the opinions and points of view of those who took issue, on whatever basis. Almost invariably the discussion ended in a salutary fashion.

Further steps included arranging for extra attention by housekeeping personnel to assure cleaning the employees' lounge in question—with the proviso and understanding that the employees with whom we held the discussion would do their part to maintain cleanliness therein, as they do in their own homes. Other steps included rearranging signs in some lounge areas to make the policy clearer to visitors. Generally almost everybody with whom such discussions were held was reasonable and cooperative. In the rare instance to the contrary (with a patient), the problem eased in time as the patient's already planned discharge helped end the impasse.

In the early months after May 7, 1987 most interesting was the diminishing use of the three "privileged" lounge areas on the medical-surgical floors. To verify that, head counts were taken during postlunch and postsupper "allowed" times. By August 1987 these exceptions were clearly superfluous and, in fact, counterproductive, serving mostly to confuse visitors about the rules. Accordingly, with medical board concurrence, an explanatory memorandum was issued on August 11, 1987 as an update report to the staff, withdrawing the exceptions for these three lounges, as well as one psychiatric floor with similar findings.

In the same vein, an explanatory memorandum was issued to the staff at the first anniversary (May 1988), reporting continuing satisfactory progress and withdrawal of exceptions for an additional psychiatric floor. It also remarked on a key development: the welcome action taken by New York City in adopting its No-Smoking Ordinance, which went into effect on April 5, 1988 and has added to the general spirit of compliance.

On a total overview, the chairman's earliest percentage appraisal, after conducting inspections with fellow committee members, often on an individual ad hoc basis, was 80-85% compliance in late May of 1987, soon after application of the policy. It was close to 90% by August 1987, and appears to have been steadily improving. At this stage more than a year later it is

approximated to be 95% or higher, to the point of being a nonproblem. (These are still gross approximations from such personal polling of hundreds of staff members, visitors, and patients. Careful gathering of more exact and meaningful data is planned but not yet accomplished.)

## REVIEW OF LITERATURE

Any approach to past work in this field must first acknowledge the early literature. Even as far back as 1841 the celebrated Thomas Hodgkin had "denounced the evils of tobacco" and recognized that "smoking tends to encroach on the freedom and comfort of others."[20] Dating back to 1950, Wynder and Graham,[21] in a classic clinical, statistical, and pathological study, called attention to the hazard of lung cancer for those who smoked cigarettes. A later scholarly personal essay by Ochsner[22] in 1973 harkens back to that classic report and updates sad reflections of Evarts Graham who himself later became victim to the carcinogenic effects of tobacco, which he had announced to the world, but too late to save himself. His medical student co-worker, Ernest Wynder, went on to a distinguished career in research and preventive medicine, and published reports of pioneer experiments and related observations[23-25] as did Auerbach,[26-28] Hammond,[29-31] and others.[32] The recent scholarly paper by Steinfeld[33] puts this aspect of the field into a proper perspective.

A second significant phase in the literature was underscored by the first public policy declaration in 1964[34] when the Surgeon General of the U.S. Public Health Service pointed out the multiple hazards to men who smoke. In the next report, issued in 1967,[35] the Surgeon General highlighted that female cigarette smokers similarly have increased mortality risks although somewhat lower than those for males. At yearly intervals, later biennial, similar timely reports have been issued.

Since the publication of Wynder and Graham[21] in 1950, it is now beyond dispute that active tobacco smoking causes carcinoma of the lung. By now it is similarly accepted as a cause for other chronic illnesses and deaths: pulmonary, cardiovascular, and others.

The newest related public health aspect has been the question of the impact of similar exposure to the nonsmoking bystander. A body of literature has been growing in the past decade on this subject, summarized extensively in the Surgeon General's Report of 1986.[2] The evidence has been mainly epidemiological and inferential.

With respect to its relationship to lung cancer, several writers (Repace and Lowry[36] in 1985; Weiss[37] in 1986; Mason[19] in 1986) address whether existing data relating passive smoking and lung cancers meet strict criteria for a causal

association. Repace and Lowry estimate 5,000 deaths annually from lung cancer as a result of involuntary tobacco smoke exposure. Weiss analyzes 11 reports between 1979 and 1986 and recognizes study flaws in some (such as too few cases studied; absence of a dose response relationship from imprecise measurement of exposure). Yet he points out that it might be difficult, if not impossible, to observe the strict criteria necessary to establish beyond doubt the causality of the association. He further points out problems in misclassification of exposure status and in accurate measurement of exposure (as in that of a spouse). He concludes that the figures of Repace and Lowry are the best current estimates of lung cancer deaths for passive smoking and that while further epidemiologic studies may offer more precise figures, they are unlikely to dispute the basic nature of the association. This is stated while conceding that there is currently no known "safe" threshold for the cause and effect, and how active and passive smoking differ in delivery of carcinogens to the respiratory tract remains unknown.

Mason notes that reported adverse effects include respiratory infections in infants of smoking mothers, increased lung cancer in nonsmoking wives whose husbands smoke, and respiratory irritation among asthmatics and other persons sensitive to cigarette smoke. He concludes that the major question is the magnitude of the risk, not the risk itself, for lung cancer among sidestream smokers, and that "the current data are sufficient for us to conclude that passive smoking causes a significant risk to the public and should be curtailed."

These reviews place great weight on the studies of Garfinkel, Auerbach, and Joubert[38] in the United States as well as those in Japan (Hirayama[39]) and in Greece (Trichopoulos and associates).[40] These investigators have attempted to correct for misclassification (of smoking and nonsmoking wives), and their data still suggest a positive association.

Among understandable reasons for questioning the existence of a hazard (while granting that an annoyance may result) is the claim of effectiveness of a closed room for undisturbed smoking in privacy. Kossuth,[41] in a recent letter, discusses this in relation with the "tight building syndrome" in which products of tobacco smoke recirculate in the enclosed air system in modern buildings. He explains the basic fallacy in viewing private designated smoking areas protective to the nonsmoker. The same point is considered in the Surgeon General's report of 1986.[2] A related conclusion is drawn therein (page 13): "The simple separation of smokers and nonsmokers within the same air space may reduce, but does not eliminate, the exposure of nonsmokers to environmental tobacco smoke."

And finally we should heed that impressive 334 page report of the Surgeon General in 1986: *The Health Consequences of Involuntary Smoking*[2] which adds to the above reference material the authority of his respected office. The report is based upon a critical review by dozens of experts of all available published scientific evidence pertaining to the health effects of environmental tobacco smoke exposure on a nonsmoker. In his words this added up to "enough warning signals to warrant calling this smoke a health hazard to which people should not unwillingly be subjected."[42]

Most proponents of this point of view recognize that the basic studies and publications that relate passive smoking to evidence of an overall increase in health problems are mainly epidemiologic. Some [respected voices] hold a contrary view, claiming the result is more an annoyance than a hazard and a threat to health. It is most reasonable, while additional studies continue, to accept the overall existing evidence as justifying the action urged by the highest medical governmental authority in the nation and espoused herein. This writer also suggests that all who remain unconvinced read the massive and impressive report of the Surgeon General which makes an overwhelmingly strong case.

## THE YEAR OF THE NONSMOKER

This phrase has been adopted widely as characterizing the year 1986. It says in a meaningful phrase what becomes obvious from the increasing groundswell of information and support during that period for the type of program we are discussing here. This came from many sources, led most effectively by the Surgeon General, to whose significant pronouncements we have already made reference.

Additionally, as references[1,3-19,36-38,41-50] already reflect, there was accompanying confirmation and support from all levels of government (federal, state, municipal) throughout the country; from the various military branches of service; from the American Medical Association and the American College of Physicians; from respected public health organizations; from individual physicians and scientists; from the press.

Most (not all) of this outpouring was stimulated by the additional factor of passive smoking as a hazard rather than the previous concentration, by and large, on the effect upon the individual smoker. It is difficult to resist concluding that the public, the press, and industry in general were finally won over to this danger to the "innocent" bystander.

The onus has shifted. The pendulum now favors the nonsmoker when questions arise at the work site. No longer is the smoker receiving the benefit

of the doubt when the cafeteria or worksite is being examined to accommodate disputants, more than 70% of whom are generally nonsmokers.

Not all of this public and governmental surge has been successful. The regulation proposed in 1986 by the Public Health and Planning Council of New York State met with a legal challenge which has been upheld by three court jurisdiction levels and, in effect, referred to the Legislature. Yet it was nonetheless pointed out by the Appellate Division that there is "ample scientific support for the conclusion that environmental tobacco smoke is harmful to non-smokers."[51] Other rebuffs continue in the repeated victories won by the Tobacco Institute in court in opposing individual case claimants.[52] On the other hand, New York City did finally enact a significant limitation on smoking as of April 6, 1988.

## DISCUSSION

What started this quest is clear: the conviction that passive smoking exposure could now be accepted as hazardous to those innocently exposed to the noxious effects of tobacco. This premise is an underpinning of the program. While other (many) benefits to individual smokers, to the institution, et al., are welcome, they remain peripheral dividends.

To this is added the obvious appropriateness for a medical institution to pursue this policy for its employees, staff, and patients. To do otherwise is anomalous.

Another important point: the careful preparation for announcing and effecting this policy, once the decision was made to pursue it, is another bedrock on which acceptance and eventual success of such program will rest. That entire preparation (conforming to good extent with published advice on the subject[53]) includes a number of successive steps, as follows:

> Study the issue before adopting a policy recommendation. This includes research of the subject as well as awareness of the organization of the institution. Proceed through medical board initiative and support, primarily; but simultaneously be assured of commitment from top administration, and obtain endorsement at an appropriate stage from the board of trustees. Following policy adoption formulate a specific program and plan its implementation. Achieve employee concurrence or cooperation. During the first stage of implementation (preparing for announcement of policy) educate and orient key staff on forthcoming announcement, and plan widespread program of education and explanation, plus support for smokers on staff. Announce the policy. Publicize to (and orient) all related staff and "family" on the background and goals of the program (information, education, incentive). Implement the policy. Monitor the application of the policy. Make modifications as need be toward total application. Appraise derived benefits.

On review of this list, all are important, particularly in the chronological order in which they are undertaken. Several stand out as vital. The two lynchpins are, first, the takeoff through medical board initiative, continued identification and support, and, second, almost simultaneous assurance of commitment by the administration. The medical board imprimatur is of major importance because the administration, staff, patients, public (and trustees) will trust and rely on the underlying medical and scientific premise which validates such significant undertaking. This will come up time after time when resistance to its acceptance is encountered. Unless the physicians are thoroughly involved and strongly committed, the effort has no launching or enduring strength.

The administration must be totally committed for the obvious reason of practicality in effecting all aspects of the preparatory and applying steps. Here, too, there can be a significant effect upon morale and cooperation of employees when they see that all levels of the staff support and comply. Nothing would sow more seeds of failure in the program than uneven compliance among all levels of the staff structure. This point was specifically made in a cover story in *Business Week*,[54] which said: "...programs work best when...smoking cessation...policies apply everywhere—from switchboard to boardroom."

A medical staff representative is preferable for leadership in the initial study phase. The reason for this is much the same as given above for the need for medical board input from the very start. Leadership in the Committee which subsequently implements the policy and program is important to consider. The chairmanship is a rigorous and demanding role, bordering on the full-time for a significant period. That person, from administration or medical staff, had best have credibility with the hospital personnel as a whole. The Committee must have sufficient elements and representation to assure commitment and cooperation from all segments of the institution. Both committees should have ample input from personnel who currently smoke.

The chairman must be prepared to receive calls upon his time from near and far. He must become accustomed to cooperate closely with public affairs colleagues and be available for interviews with press and television. He must become knowledgeable on matters of publicity and how to plan for their most effective impact on the institution's staff and visitors.

In addition there will be calls for information and advice from other medical institutions and organizations who have similar interests and who deserve, of course, to receive the benefits of this experience. This has been given as freely as possible, even with personal orientation sessions of staff groups

from other institutions, as well as by supplying copies of key memoranda and publicity mechanisms such as buttons, brochures, flyers, and even posters. It is in the spirit of being of assistance to other institutions who may be interested in this experience that this report is compiled.

Another necessary element is the willingness of principals in this endeavor to be available to respond to questions and need for guidance from staff at all levels. The chairman of such a committee and its members had best be open to queries and personal approaches—and be of mind and mood to give time as well to ad-hoc "inspections" during the course of rounds. They had best be blessed with endless patience, of which one never has enough, and a belief in the correctness of the program, else be shaken at times by the unexpected.

## ADDICTION ASPECTS OF TOBACCO

The Surgeon General's most recent 20th Report of May 8, 1988, *The Health Consequences of Smoking: Nicotine Addiction,* has heightened awareness that tobacco smoking is a real addiction. It fulfills criteria for drug dependency despite absence of governmental limitation on its sale without special prescription or, as with alcohol, by a specific license to sell and which may be revoked for repeated sales to minors. (The last is a legal requirement in New York State, but not fully applied.)

The Surgeon General's proper warning may have at the same time served to overstress the addictive factor in one sense. Approximately 90-95% of habitual smokers (drug addicts?) do discontinue smoking on their own, as opposed to a considerably smaller percentage of 30% for opium users. That suggests that we are dealing, in the tobacco-area problem, with a less tenacious continuance. Smoking cessation in the hospital is pursued for the reasons already made clear. Under the effective, persuasive auspices of the hospital environment this campaign and program for cessation is also intended to encourage and help the addict to nicotine (when the shoe fits) to discontinue the habit.

## SUMMARY

Beth Israel Medical Center committed itself to a smoke-free environment on May 7, 1987 after seven months of careful study by a policy determination committee and, thereafter, seven months of meticulous planning for its announcement and implementation. The policy rests on two premises: passive smoking is harmful to nonsmokers; a medical center "employer," above all others, has a special, impelling obligation to shield persons in its environs from such exposure. The impetus came from the medical staff. The policy

acceptance and commitment had the combined approval of the medical staff, administration, and trustees.

The ban applies to all who serve, are served in, or otherwise visit the Center.

Care was taken to prepare all staff and patients for the stringent policy effective May 7, 1987. Its medical basis was made clear. Support was arranged for smokers who were interested. Response in the first year and a half has been increasing acceptance, which reflects careful preparation as well as in depth support from the medical staff. Problems are met with discussion and reasoning, not punitively.

## ACKNOWLEDGEMENTS

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